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	175044	A. BUILDING _____ B. WING _____	02/25/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 95 residents, with a sample of 15 residents. Based on observation, interview, and record review the facility failed to have ongoing activities on the evenings and weekends, and failed to have an individual activity program for 1 (#24) of 3 residents sampled for activities. Findings included: - The Quarterly Minimum Data Set (MDS) dated 1/26/15 for Resident #24 listed a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. The resident required extensive assistance of two staff for bed mobility, transfers and toileting. He/she required extensive assistance of one staff for dressing and personal hygiene. The Annual MDS assessment dated 8/11/14 listed long and short term memory problems. The staff assessment of daily activity preferences included the resident preferred snacks between	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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meals, spending time outdoors and participating in religious activities.

The Care Area Assessment for Cognitive Loss/Dementia dated 8/10/14 revealed the resident was hard of hearing and had days where the resident accepted assistance more than on others. Staff did not feel he/she has had a significant change in mood or had lost interest or pleasure in doing things.

The CAA dated 8/21/14 for activities revealed the resident ' s family member continued to visit several times per week and was a great source of comfort and support to the resident. Staff did not feel the resident had lost interest or pleasure in doing things he/she normally liked to do or that he/she was feeling down, depressed or hopeless. The resident continued to reside in his/her private room where he/she benefited from the structured environment and the programs available. The Resident continued to enjoy being around others but also enjoyed having his/her alone time in his/her room, and enjoyed bus rides with other residents.

The care plan for activities dated 2/11/15 revealed the resident continued to enjoy being around others, but mainly preferred self-initiated activities and preferred being in his/her room much of the time. He/she enjoyed bus rides with other residents, and attended music programs at times. He/she would sit and relax in the living room on occasion.

The activity assessment dated 2/4/15 listed too many people can be confusing and

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overstimulated the resident. His/her preferred activity settings in the resident's room and small groups. The resident's daily pattern consisted of the resident in a recliner in his/her room and naps. One to one activities consisted of conversation in the morning and afternoon. Wheel the resident around in his/her wheel chair, and sit in the recliner. The resident can become anxious, excitable, aggressive, demanding, depressed, non-talkative, suspicious, belligerent, fearful, or talkative. The resident preferred solitude; he/she was withdrawn, cooperative, and quiet. The purpose/outcome revealed the resident ' s activity program was to maintain the resident's functional levels. The resident would be supported and or have a supportive environment, a sense of initiative and involvement, and be at ease interacting with others.

The quarterly activity progress note dated 1/30/15 revealed the resident continued to benefit from the unit's structure and programing. The resident preferred 1:1 activities over group activities, he/she enjoyed having staff sit and visit with him/her. The resident liked to listen to calming music in his/her room, and did better with low key activities. The resident became easily over stimulated in activities involving large groups so they were usually avoided, he/she could enjoy music programs if the resident sat around the perimeter of the group. The resident enjoyed rides around the main courtyard when the weather was nice. The resident's family member visited him/her several times a week, one of the resident's main enjoyments continued to be eating popcorn, staff will continue to support the resident in his/her participation of self-initiated

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activities and offer both 1:1 and small group activities.

Review of the activitity log for Feburary 2015 revealed the resident participated in 15 unnamed activities, Exercise/sports one time, Music 5 times, Watching Television 3 times, Talking/ conversing 12 times, One on one activity 4 times and Namaste (lotion application) 2 times.

Review of the activity logs January 2015 revealed the resident participated in 24 unnamed activties, Music 6 times, Reading/writing 1 time, Watching television 6 times, Talking/ conversing 22 times, One on one activity 6 times, and Namaste 3 times.

Review of the December 2014 program revealed the resident participated in 24 unnamed activities, Exercise/sports 1 time, Music 5 times, Reading/writing 2 times, Watching television 4 times, Talking/ conversing 23 times, and one on one activity 3 times.

On 2/18/15 at 3:17 P.M. the resident attended a group activity of trivia the resident was not involved in activity. Staff moved the resident around the unit and returned the resident to his/her room at 3:30 P.M.

On 2/19/15 at 10:50 A.M. the resident was not on the unit for the activity of reminiscing and exercise. Exercise did not take place.

On 2/19/15 at 11:26 A.M. staff brought the resident back from the beauty shop. Staff took

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the resident to his/her room and toileted the resident. He/she was then brought out to the dining room, where the resident complained of being uncomfortable and was returned to his/her room.

On 2/19/15 at 3:25 P.M. the resident sat in his/her room in the recliner no radio or tv were in the resident's room there was no calming music playing.

Review of the activity schedule for the unit revealed on 2/19/15 at 2:30 P.M. residents went on a bus ride, the resident did not attend.

On 2/23/15 at 1:15 P.M. direct care staff Q stated the resident did not want to be out in the living room he/she stayed in his/her room otherwise would have behaviors. We talk about anything he/she wants to, Kansas city, that is where he/she was from , where his/her spouse worked, and his/her spouse and daughter. The resident did not go on bus trips any longer as he/she had behaviors on the bus and when he/she went out to eat would try to escape. The resident did not have a television or radio in his/her room there is no calm music played when the resident is in his/her room, there had not been a radio in the room as long as I have worked here.

On 2/23/15 at 3:30 P.M. licensed staff H stated the activity program in the unit for the residents was posted weekly, the resident's take bus trips, go out to lunch,and go out to the other units for activities.

On 2/23/15 at 5:15 P.M. administrative nursing staff D stated the activity assessment was filled

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out by a certified activity aide, the activity director would review it, a then look at it and input. The 1:1 activity program was based on the resident. Talking about the things with the kaizan (direct care staff). The resident had a radio in his/her room to listen to but it was broken. The bus rides were talked about with the family member and he/she wanted it left on the care plan and we would offer it to him/ her, however he/she had not been on a bus ride in 2-3 months. The resident was talked to by staff and did not attend group activities very long. Staff D confirmed the activity program was not individualized for this resident.

The facility failed to have an individualized activity program for this cognitively impaired resident.

- During Stage 1 of the survey on 2/16/15 and 2/17/15 several alert and oriented residents expressed concerns regarding evening and weekend activities. One of the residents stated evening activities were only a movie.

Review of the facility's January 2015 activity calendar revealed Saturday activities included a bus ride at 10:00 A.M. and on 1/10/15 a Alzheimer's support group scheduled at 10:00 A.M. at the same time as the bus ride. Sunday activities included a religious service at 2:30 P.M. and on 1/4/15 a children's choir was also scheduled at the same time as the religious

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service.

The facility's February 2015 activity calendar revealed Saturday activities included a bus ride at 10:00 A.M. and on 2/14/15 an Alzheimer's support group at 10:00 A.M. as well as the 10:00 A.M. bus ride. Sunday activities included a religious service at 2:30 P.M., on 2/1/15 a children's choir also scheduled at 10:00 A.M. and on 2/28/15 an art class at 10:00 A.M. in addition to the bus ride.

Review of the Eagle Ridge activity schedule for 2/15/15 to 2/21/15 included Sunday activity for 2/15/15 included 10:00 A.M. morning activity with staff daily exercise group at 1:30 P.M. , 2:30 P.M. religious service and afternoon activities with staff and at 6:30 P.M. evening activities with staff. Saturday 2/21/15 activities included a bus ride at 10:00 A.M., 1:30 P.M. daily exercise group, 2:30 afternoon actives with staff and at 6:30 P.M. evening activities with staff.

Further review of the Eagle Ridge Activity Schedule included a notation read daily activity interest should be shared with your Kaizen (direct care staff) and the activity calendar only reflected scheduled events and not daily interest.

On 2/23/15 at 11:35 A.M. direct care staff TT stated evening activities on Eagle Ridge after dinner was a movie a couple of evenings each week. He/she stated weekend activities included songs, Bingo and arts and crafts. Direct care staff TT stated weekend evening activity scheduled at 6:30 P.M. was a movie.

On 2/25/15 at 1:25 P.M. licensed nurse N stated weekend activities from 6:00 A.M. to 2:00 P.M.

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F 248	Continued From page 7 included baking, arts and crafts and bus rides on Saturdays. On 2/23/15 at 5:05 P.M. administrative staff C stated the facility monthly activity calendar was for all residents in the facility regardless of the neighborhood the resident resided. Administrative staff C stated each neighborhood also had their own activities and the Kaizen asked each resident on the neighborhood prior to the start of the activity what activity the resident would like to do. Administrative staff C stated there was no written documentation to ensure weekend and evening activities were based on the resident's interest. The facility failed to ensure an on-going program of activities during the evening and on weekends for the residents in this unit.	F 248		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		

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and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 95 residents, with a sample of 15 residents. Based on observation, interview, and record review the facility failed to update the care plan to identify the activity program the resident received for 1 (#24) of 3 residents sampled for activities.

Findings included:

- The Quarterly Minimum Data Set (MDS) dated 1/26/15 listed a Brief Interview for Mental Status (BIMS) score for resident #24 of 6 indicating severe cognitive impairment. The resident required extensive assistance of two staff for bed mobility, transfers and toileting. He/she required extensive assistance of one staff for dressing and personal hygiene.

The Annual MDS assessment dated 8/11/14 listed long and short term memory problems. The staff assessment of daily activity preferences included the resident preferred snacks between meals, spending time outdoors and participating in religious activities.

The Care Area Assessment for Cognitive Loss/Dementia dated 8/10/14 revealed the resident was unable to complete his/her own assessment due to long and short term memory loss, therefore staff were interviewed regarding

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preferences. The resident was very hard of hearing, had days where the resident accepted assistance more than on other days. Staff did not feel he/she has had a significant change in mood or had lost interest or pleasure in doing things. Will care plan to provide support and visit as needed and assess for any change in mood or cognition

The CAA dated 8/21/14 for activities revealed the resident ' s daughter continued to visit several times per week and was a great source of comfort and support to the resident. Staff did not feel that he/she has had a significant change with his/her mood. Staff did not feel the resident had lost interest or pleasure in doing things he/she normally liked to do or that he/she was feeling down, depressed or hopeless. The resident continued to reside in his/her private room on the Meadowlark neighborhood where he/she benefited from the structured environment and the programs available. The resident enjoyed snacks in between meals and usually preferred popcorn, continued to enjoy being around others but also enjoyed having his/her alone time in his/her room and Enjoyed bus rides with other residents. Will care plan to continue to monitor for changes in mood/cognition and to provide 1:1 support as needed.

The care plan for activities dated 2/11/15 revealed when the resident felt up to snacking he/she enjoyed popcorn, he/she continued to enjoy being around others, but mainly preferred self-initiated activities and preferred being in his/her room much of the time, he/she enjoyed bus rides with other residents, and will attend music programs at times. He/she would sit and

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relax in the living room on occasion.

The activity assessment dated 2/4/15 listed too many people can be confusing and overstimulated the resident. His/her preferred activity settings was in the resident's room and small groups. The resident's daily pattern consisted of the resident in a recliner in his/her room and naps. One to one activities to consist of conversation in the morning and afternoon. Wheel the resident around in his/her wheel chair, and sit in the recliner. The resident can become anxious, excitable, aggressive, demanding, depressed, non-talkative, suspicious, belligerent, fearful, or talkative. The resident preferred solitude; he/she was withdrawn, cooperative, and quiet. The purpose/outcome revealed the resident ' s activity program was to maintain the resident's functional levels, the resident would be supported and or have a supportive environment, a sense of initiative and involvement, and be at ease interacting with others. Information obtained from family member and chart.

The quarterly activity progress note dated 1/30/15 revealed the resident resided on the Meadowlark neighborhood and continued to benefit from it's structure and programing. The resident preferred 1:1 activities over group activities, he/she enjoyed having staff sit and visit with him/her. The resident liked to listen to calming music in his/her room, and did better with low key activities. The resident became easily over stimulated in activities involving large groups so they were usually avoided, he/she could enjoy music programs if the resident sat around the perimeter of the group. The resident enjoyed rides around

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the main courtyard when the weather was nice. The resident's daughter visited him/her several times a week, one of the resident's main enjoyments continued to be eating popcorn, staff will continue to support the resident in his/her participation of self-initiated activities and offer both 1:1 and small group activities.

Review of the activitity log for Feburary 2015 revealed the resident participated in 15 unnamed activities, Exercise/sports one time, Music 5 times, Watching Television 3 times, Talking/ conversing 12 times, One on one activity 4 times and Namaste (lotion application) 2 times.

Review of the activity logs January 2015 revealed the resident participated in 24 unnamed activties,Music 6 times, Reading/writing 1 time, Watching television 6 times, Talking/ conversing 22 times, One on one activity 6 times, and Namaste 3 times.

Review of the December 2014 program revealed the resident participated in 24 unnamed activities, Exercise/sports 1 time, Music 5 times, Reading/writing 2 times, Watching television 4 times, Talking/ conversing 23 times, and one on one activity 3 times.

On 2/18/15 at 3:17 P.M. the resident attended a group activity of trivia the resident was not involved in activity. Staff moved the resident around the unit and returned the resident to his/her room at 3:30 P.M.

On 2/19/15 at 10:50 A.M. the resident was not on

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the unit for the activity of reminiscing and exercise. Exercise did not take place.

On 2/19/15 at 11:26 A.M. staff brought the resident back from the beauty shop. Staff took the resident to his/her room and toileted the resident. He/she was then brought out to the dining room, where the resident complained of being uncomfortable and was returned to his/her room.

On 2/19/15 at 3:25 P.M. the resident sat in his/her room in the recliner no radio or tv were in the resident's room there was no calming music playing.

Review of the activity schedule for the unit revealed on 2/19/15 at 2:30 P.M. residents went on a bus ride, the resident did not attend.

On 2/23/15 at 1:15 P.M. direct care staff Q stated the resident did not want to be out in the living room he/she stayed in his/her room otherwise would have behaviors. We talk about anything he/she wants to, Kansas city, that is where he/she was from , where his/her spouse worked,and his/her spouse and daughter. The resident did not go on bus trips any longer as he/she had behaviors on the bus and when he/she went out to eat would try to escape. The resident did not have a television or radio in his/her room there is no calm music playied when the resident is in his/her room, there had not been a radio in the room as long as I have worked here.

On 2/23/15 at 3:30 P.M. licensed staff H stated the activity program in the unit for the residents

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F 280	Continued From page 13 was posted weekly, the resident's take bus trips, go out to lunch,and go out to the other units for activities. On 2/23/15 at 4:32 P.M. with administrative staff C stated if the care plan does not address what the resident was involved in then it is inaccurate. duplicate On 2/23/15 at 5:15 P.M. administrative nursing staff D stated the activity assessment was filled out by a certified activity aide, the activity director would review it, a then look at it and input. The 1:1 activity program was based on the resident. Talking about the things with the kaizan (direct care staff). The resident had a radio in her room to listen to but it was broken. The bus rides were talked about with the daughter and she wanted it left on the care plan and we would offer it tohim/ her, however he/she had not been on a bus ride in 2-3 months. The resident was talked to by staff and did not attend group activities long. Staff D confirmed the activity program was no individualized for this resident. , I think I would just state that staff D confirmed the acitivity program was not individualized and the care plan was not updated. The facility failed to update the careplan for activities for this cognitively impaired resident.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 95 residents. The sample included 15 residents. Based on observation, interview and record review, the facility failed to do neurological checks for 2 of 3 cognitively impaired residents sampled for accidents. (#27, #99) The facility failed to complete one neurological assessment for 1 of 3 residents sampled for accidents. (#99)

Findings included:

- Resident #99's Annual Minimum Data Set (MDS) dated 11/24/14 documented the resident's Brief Interview for Mental Status Score (BIMS) of 5, which indicated the resident had severe cognitive impairment. The resident required supervision of one staff with bed mobility, transfers, walking in his/her room and corridor, toilet use and personal hygiene. The resident had one fall with no injury since his/her admission or the prior assessment.

The Fall Care Area Assessment (CAA) dated 11/24/14 documented the resident had a fall on 10/21/14 with no injuries. He/she was at risk for falls due to the dementia (progressive mental disorder characterized by failing memory, confusion) process, medication use, use of his/her walker to ambulate (walk) independently with supervision, and his/her inconvenience. What inconvenience?

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The Fall care plan dated 12/3/14 documented the resident was encouraged to ask for assistance if he/she was feeling weak or dizzy and keep his/her walker within reach., The plan instructed staff to place his/her bed in view of the door, educate the resident on call light use and demonstrate correct usage, instruct the resident to use his/her grab bars, the resident's family did not want his/her bed moved but agreed rearrange the room for better mobility, ensure the room was clutter free, physical and occupational therapy were to evaluate and treat the resident for instability, and after the resident was seated at the dining table staff would ensure his/her needs and wants were met before leaving his/her table.

A nurses note dated 7/21/14 at 5:56 P.M. from licensed nursing staff L documented the resident was alert with increased confusion that day. He/she was disoriented to time, place, and situation. The resident kept repeating, "I don't know why I am here. I don't know where we are supposed to be. Our clothes are here, our socks are here, but I don't know where I am."

The nurse ' s note dated 10/21/14 at 12:35 A.M. from licensed nursing staff K documented at 12:15 A.M. staff overhead the resident calling his/her spouse. When staff opened his/her door staff saw the resident sitting on the floor beside his/her bed. The resident was not able to state how he/she fell but stated, "I think it ' s still off the hook," and pointed to the phone next to the bed. The phone was off of the cradle. Neurological checks were not initiated, the resident denied hitting his/her head.

The nurse ' s note dated 1/8/15 at 11:45 P.M. from licensed nursing staff K documented at 8:00

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P.M. a certified nurse aide (CNA) stated the resident was on the floor in his/her bathroom. The resident reported he/she stood up from the toilet and lost his/her balance. The resident stated he/she fell onto his/her laundry basket in front of the toilet and hit his/her back. Neurological checks were not initiated, the resident denied hitting his/her head.

The nurse's notes dated 1/22/15 at 7:33 P.M. from licensed nursing staff J documented at 9:00 A.M. staff said the resident was on the floor in his/her bathroom. The resident stated he/she thought he/she hit his/her head "a little" on the wall when he/she fell down.

The neurological check dated 1/22/15 through 1/23/15 included 11 assessments with date, time, temperature, pulse, respirations, blood pressure, pupil difference, hand grasp strength, comment, and initial of the nurse doing the assessment. 10 of the assessments did not include the resident's temperature.

A nurses note dated 1/24/15 at 3:21 P.M. from licensed nursing staff M documented the resident was more confused that morning than usual. He/she was looking for "the kids" and was sure he/she had more rooms reserved with other family members staying.

An observation of the resident on 2/23/15 at 10:39 A.M. revealed he/she ambulated from his/her room with his/her walker without assistance from staff.

An interview on 2/23/15 at 10:46 A.M. direct care staff V stated he/she , required standby assistance from staff. and his/her memory was

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not the greatest and at times sometimes believed he/she had kids at the facility.

An interview on 2/23/15 at 11:34 A.M. with licensed nursing staff L stated the resident answered questions appropriately unless he/she was fixated on something He/she revealed if a resident fell and there were no witnesses neurological checks should be done.

An interview on 2/23/15 at 12:55 P.M. with administrative nursing staff D stated the policies given for the neurological checks of residents who fell included, when a resident had a BIMS of 3 through 7 and could tell staff whether they hit their head or not, neurological checks were not typically completed. When a resident had a BIMs of 3 through 7 and their cognition varied over the course of a day, he/she would expect neurological checks to be completed. I would take this out

An interview on 2/23/15 at 4:47 P.M. with administrative nursing staff D stated he/she would expect neurological checks to be completed for resident #99 for unwitnessed falls whether or not the resident stated he/she hit his/her head or not. Staff D further revealed that the neurological assessment sheets were to be completely filled out as directed on the sheet and this included the residents temperature.

The Care for the Elder that has Fallen policy, dated 10/11/14, documented when an elder fell the caregiver present during the fall stayed with the resident. If there were signs and symptoms of a head injury then neurological checks would begin. Staff were to attain a statement from the resident about what happened. The resident

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would be assessed and documented on every shift for the next 72 hours. Neurological checks would be implemented when the resident reported he/she hit his/her head or if an injury was noted.

The facility failed to provide and complete neurological assessments for this severely cognitively impaired resident who had 3 unwitnessed falls.

- Diagnosis on the electronic record for resident #27 listed dementia without behaviors (a category of brain diseases that cause a long term and often gradual decrease in the ability to think and remember such that a person's daily functioning is affected.)

The quarterly Minimum Data Set (MDS) dated 1/26/15 listed the resident with a Brief Interview for Mental Status (BIMS) of 7 indicating severe cognitive impairment. The resident did not have falls listed on the assessment.

The annual MDS dated 5/26/14 BIMs of 7 indicating severe cognitive impairment. The resident did not have falls listed on the assessment.

The Care Area Assessment (CAA) for falls dated5/21/14 revealed the resident did not experience falls, was at risk for falls related to his/her memory loss, used an assistive device and use of multiple medications which include pain and antidepressant medications.

The CAA for Cognitive Loss/Dementia dated 5/21/14 listed the score of 6/15 on the BIMS

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assessment, a 3 point decrease from the previous assessment, this score was indicative of severe cognitive impairment, and cognition fluctuated over the course of the day, he/she continued to believe he/she has lived at Brewster a few months but was here since 2010.

The care plan for falls dated 2/11/15 listed the resident would not have injury from falls, or experience drug related effects through the next review. The resident received pharmacological interventions for cognitive loss and depression, the potential side effects from medications could increase the risk for falls and injuries. Due to cognitive loss he/she will forget to use the call light, staff were to monitor the resident and encourage the resident to use the call light. Staff needed to assist the resident with standing due to stiffness in his/her knees and required staff to stay with the resident with night time cares and assure he/hse had non-skid socks/shoes on.

Review of the Fall risk assessment dated 10/17/14 revealed a score of 25 which indicated high risk for falls

Nurses notes (NN) dated 2/7/15 4:40 P.M. revealed kaizen came to get nurse and the elder was found on the floor in a sitting position with knees up to chest, denied hitting head and stated " I don ' t know " when questions asked. Active range of motion to all extremities was within normal limits. Vitals signs temperature 97.6, Pulse 64, Respirations 18, blood pressure 40/8340/83 holy cow, no pain or discomfort, dementia director, physician and caretaker notified.

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NN 2/8/15 1 :39 P.M. elder up in chair in room continues to state he/she doesn ' t know when he/she fell.

NN 2/8/15 3:27 P.M. ambulation with walker and one person assist elder reports some soreness form fall on right side, no redness. Range of motion to all extremities within normal limits.

NN 2/10/15 at 3:00 A.M., elder remained a follow up for non-injury fall, he/she was alert and oriented to person, disoriented to time, place and situation.

Review of the medical record revealed neurological checks were not performed for this resident following the fall of 2/7/15.

Review of the facility investigation dated 2/7/15 at 4:40 P.M. listed the resident was found sitting with his/her legs bent up towards the chest. Fall summary listed the resident was found on the floor unwitnessed self-reported fall. The location listed was the bathroom, he/she stated I don' t know, how I just fell. The resident was alone and unattended. When asked what he/she was doing the resident stated it must have been when I was getting ---------- . Mental status listed as same, the resident wore shoes at the time of the fall, he/she did not use alarms and was last toileted at 4:40 P.M. and after lunch. The fall huddle revealed the resident attempted to pull up a brief and maybe slipped or sat down. The root

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cause of this fall was listed as the amount of staff assistance in effect. The initial root cause of the fall Not enough staff assistance. Interventions to prevent future falls were listed for staff to be with him/her when the resident transferred from the toilet to a standing position reminding him/her to use call light. Summary listed the elder needed more assistance to toilet. Elder needs staff to anticipate needs prompt at 4:30P.M.

On 2/18/15 at 1:30 P.M. the resident was sleeping in the reclining chair curled to the right side slumping to edge of chair, shoes were in place.

On 2/19/15 at 2:45 P.M. the resident sat in the living room in a recliner listening to the television and sleeping, with shoes in place.

On 2/19/15 at 3:15 P.M. direct care staff R stated he/she needed assistance when going to the bathroom and needed to be reminded to use the call light and his/her bed needed to be in a position were he/she can place his/her fee on the floor. Staff R revealed that he/she was a fall risk

On 2/23/15 at 1:30 P.M. direct care staff Q stated if a resident had an unwitnessed fall the nurse assessed the resident, we have a round table discussion of what happened and what to do to prevent it from happening again.

On 2/23/15 at 1:30 P.M. licensed nurse H stated resident #24cognition varied and would do

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neurological checks if he/she had an unwitnessed fall. Staff H further revealed that the policy stated if an unwitnessed fall occurred and the resident could tell you if they hit their head neuro checks were not initiated, but on the dementia unit it would be different, the resident would aslo be assessed for indications that the resident hit his/her head.

Review of the policy titled Caring for the Elder that has fallen dated 10/11/14 revealed when an elder fell, the caregiver stayed with the elder. The staff monitored for signs and symptoms of a head injury and if postitive neuro checks are begun. The elder will be assessed and documented on every shift for the next 72 hours. Neuro checks will be implemented when the resident reported that he/she hit his/her head or an injury is noted.

Interview on 2/23/15 at 12:55 P.M. Administrative staff D confirmed the policies given earlier covered the neuro checks for residents that fell. If the resident could tell the staff they did not hit their heads neuro checks were not initiatiated. Staff D revealed that if a residents cognition varied over the course of the day neuro checks should be completed.

On 2/23/15 at 5:45 P.M. Administrative nursing staff D confirmed neuro checks were not completed for this resident.

The facility failed to monitor this severely cognitively impaired resident's neurological status following an unwitnessed fall.

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F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 95 residents. The sample included 15 residents. Based upon observation, record review and interviews the facility failed develop and implement timely interventions to prevent the development of an avoidable pressure ulcers and to promote the healing of pressure ulcer for 1 of 2 residents sampled for pressure ulcers (#6).

Findings included:

- Resident #6's diagnoses listed on the electronic record included closed fracture of the pelvis, muscle weakness, abnormality of gait, lower leg joint pain, difficulty in walking, osteoarthrosis (,chronic arthritis without inflammation), scoliosis (curvature of the spine), venous embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the blood stream) and thrombosis (clot that developed within a blood vessel).

The Admission Minimum Data Set (MDS) dated

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10/28/14 identified the resident admitted to the facility on 10/21/14, scored 12 (moderately impaired cognition) on the Brief Interview for Mental Status (BIMS), required extensive staff assistance with bed mobility, transfers, walking in the room, locomotion on/off the unit, dressing, toilet use and personal hygiene. The resident was continent of urine, utilized a walker and a wheelchair. The MDS identified the resident was at risk for the development of pressure ulcers, had no unhealed pressure ulcers, utilized a pressure relieving device on his/her bed and chair, and was not on a turning/repositioning program.

The Significant Change Minimum Data Set (MDS) dated 1/23/15 identified the resident scored 15 on BIMS which indicated the resident had intact cognition. The MDS identified the resident required limited assistance with bed mobility, transfers, walking in the room/corridor, dressing, toilet use, personal hygiene, extensive staff assistance with locomotion on/off unit and independent with eating. The MDS coded the resident utilized a walker and a wheelchair and was occasionally incontinent of urine. The MDS identified the resident was at risk for the development of pressure ulcers and had (1) Stage 4 pressure ulcer not present upon admission that measured 2.8 centimeters (cm) by 1.0 cm and the most severe tissue type was slough. The MDS identified the resident had a pressure ulcer relieving device in his/her chair and bed, and was not on a turning/repositioning program.

The Pressure Ulcer and Nutritional Status Care Area Assessments (CAAs) dated 1/27/15

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documented the resident's pressure ulcer on his/her mid-spine was a stage 4 pressure ulcer after debridement .

The resident's Braden Scale dated 10/21/14 identified the resident scored 16, at high risk for the development of pressure ulcer.

The resident's temporary care plan with an admission date of 10/21/14 included the resident had a pelvic fracture, required assistance of 1 staff with ADLs, was continent of bowel and bladder, received a mechanical soft diet and staff performed weekly skin assessments.

The care plan did not address how staff minimized pressure on the resident's bony prominences to prevent the development of pressure ulcers.

The care plan dated 1/28/15 addressed the resident had impaired physical mobility related to a history of a pelvic fracture, the resident required stand by assistance for toileting and toileting transfers. The resident was at risk for altered nutritional status, received a mechanical soft diet, staff monitored and recorded the resident's nutritional intake, the resident's received lactose free Ensure (nutritional supplement used to increase calories and protein) as physician ordered since 11/19/14. On 1/8/15, staff offered the resident a lactose free protein shake in the P.M. and on 1/14/15 staff increased the resident's lactose free milkshakes to twice a day (BID) and on 2/4/15 the milkshakes were increased to three times a day (TID). Staff weighed the resident weekly and encouraged the resident to consume 75 percent (%) of each meal served. Since 11/6/14 staff encouraged and assisted the

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resident to change his/her position at least every 2 hours. The resident utilized a pressure relieving device on his/her bed and pressure relieving device in his/her chair. An undated entry marked through pressure reliving device on bed and and hand written entry included low air loss mattress. The resident chose not to have the heelz up cushion (device to offload the resident's feet) and the resident understood the risks (12/12/14). On 12/26/14 the resident utilized a donut pillow when he/he sat. On 12/27/14 staff discontinued the donut pillow because the resident chose not to use it. An undated entry included the resident received ProStat (supplement used to increase protein). On 1/14/15 the physician debrided the pressure ulcer on the resident's mid-back; since 2/11/15 staff cleaned the pressure ulcer on the resident's back with normal saline and covered the area with a pink polymen daily and as needed (PRN) (2/11/15). The resident received a mechanical diet, had some weight loss issues, staff offered the resident high caloric foods and the resident liked lactose free ice cream.

The care plan did not address what education staff provided the resident regarding repositioning/turning prior to the development of the pressure ulcer. The care plan also did not include alternatives regarding off-loading the resident's feet after the resident chose not to use the heel up device. The care plan did not include interventions regarding preventing skin to skin contact of the resident's bony prominences or how staff minimized the pressure prior to the development of the pressure ulcer on the resident's spine even though staff assessed the resident was at risk for the development of pressure ulcers and presented with kyphoisis

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(unnatural curving of the upper back that creates a hunchback appearance in the posture, often associated with osteoporosis (progressive bone disease characterized by a decrease in bone mass and density and can lead to a humped position) upon admission to the facility.

The skin condition forms included the following:
12/11/14 and timed 7:36 P.M. the resident had a red mark in the center of his/her spine that measured 3 cm by 3.5 cm, and a red and brown circle was in the center of the area. Staff received a physician order to apply an Elasto gel dressing (dressing used to treat pressure ulcers) daily until the area healed.
12/18/14: The resident had a dark red sac in the center of his/her spine. No measurement.
12/25/14: The area on the resident's spine went from a small scab to a bright red area 6.0 cm in diameter and a black scabbed area with a diameter of 2.0 cm. around.
1/7/15: The pressure ulcer on the resident's spine was due to persistent pressure on the resident's spine. The pressure ulcer had a black necrotic center with slough surrounding the back center, severe red raised skin surrounding the wound and measured 7.5 cm by 5.5 cm.
1/15/15: The pressure ulcer contained slough and measured 2.8 cm by 3.0 cm by 0.7 cm.
1/20/15: The pressure ulcer continued on the resident's spine and the physician debrided the pressure ulcer last week.

A nurse's note (NN) dated 12/11/14 and timed 6:47 P.M. documented after staff observed the red area on the resident's back/mid-spine staff delivered an air mattress to the resident's room that afternoon. The note included the resident's physician's gave orders that included liquid

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protein BID, a Multivitamin once a day, change the Elasto Gel dressing to the red area on the center of the resident's back/spine daily for healing and protection. Staff to elevate the resident's heels up and off the bed with a heels off pillow when the resident was in bed.

The above NN represented the facility received the orders

An interdisciplinary note dated 12/29/14 documented staff informed the physician designee the area on the resident's back worsened. The physician's designee gave orders to start Santyl (an ointment used to remove dead tissue) approximately 1 gram to the eschar (dead tissue) area directly every day, and to securely cover the area with a dressing. The note included due to the thickness of the eschar it might be necessary to crosshatch (scoring of thin cuts into the surface of the dead tissue) with a sterile blade before applying the Santyl. The Director of Nursing should evaluate the wound and determine if crosshatching was necessary and to start the resident on Keflex (an antibiotic) BID for 10 days due to cellulitis (bacterial skin infection).

A (NN) dated 1/14/15 and timed 7:12 P.M. included the pressure ulcer on the resident's spine had a moderate amount of yellowish brown drainage and no odor at this time. The physician debrided the pressure ulcer and the wound bed contained 80% slough, the surrounding peri-wound measured 3.0 cm by 2.8 cm with a depth of 0.7 cm.

A NN dated 1/17/15 and timed 9:21 A.M. included staff notified the resident's physician of the

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resident's weight loss and the resident's physician gave orders for the resident to receive a diet high in calories.

An Interdisciplinary note dated 2/2/15 and timed 10:56 A.M. (a duration of greater than a month after the resident developed the pressure ulcer on his/her mid-spine) documented the resident admitted to the facility with a diagnosis of a left fractured pelvis, and had kyphosis (unnatural curving of the upper back that creates a hunchback appearance in the posture, often associated with osteoporosis) and required limited staff assistance with transfers and ADLs. The resident received a mechanical soft diet, had weight loss and staff offered the resident lactose free foods and milkshakes BID, and lactose free Ensure and ice cream (no frequency noted). The note included on 12/11/14 staff noted the resident had a red area on his/her mid back where his/her bra line. Staff applied Elasto gel and notified the resident's physician of the red area and staff applied an air mattress to the resident's bed. The resident's physician ordered liquid protein BID, Multivitamin once day, change the Elasto gel twice daily and to offload the resident's heel when the resident was in bed. On 12/30/14 physical therapy/occupational therapy screened the resident for pressure relief. On 1/7/15 (a duration of 3 weeks after the development of the resident's pressure ulcer) the facility contacted the facility's Medical Director (not the resident's primary care physician) to assess the resident's wound due to the wound had drainage with slough around the edges. Staff educated the resident on repositioning and ways to relieve pressure. The resident did not wish to use the heels up or lie on his/her side and staff encouraged the resident to reposition.

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A NN dated 2/4/14 timed 4:06 P.M. documented the pressure ulcer measured 2.0 cm by 2.2 cm with a depth of 0.8 cm.

A (NN) dated 2/16/15 and timed 11:36 A.M. documented the pressure ulcer on the resident's spine continued to have a slight odor, a large amount of creamy yellowish/green drainage and approximately 2.0 cm of deep red intact tissue surrounded the pressure ulcer. The resident continued turning side to side when in bed and he/she continued to report minimal discomfort to the area.

A skin note dated 2/20/15 and timed 11:02 A.M. included the pressure ulcer on the resident's spine measured 2.8 cm by 1.8 cm with a depth of 0.6 cm and continued with a small amount of greenish drainage without odor.

Review of the weight log revealed the following weights:

10/28/14: 122 pounds
11/11/14: 118 pounds
12/02/14: 116 pounds
12/09/14: 114 pounds
12/16/14: 114 pounds
2/10/15: 104 pounds

A laboratory report dated 12/29/14 recorded the resident's serum albumin level at 3.4 grams/deciliter (gm/dl), normal reference range 3.6-5.3 g/dl.

A Registered Dietician's (RD) note dated 10/30/14

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included the resident received a mechanical soft diet, had no skin skin issues and did not make any recommendations.

A RD note dated 1/8/15 documented the resident had weight loss, a loss of appetite and skin issues, the resident weighed 110.6 pounds and had slowly lost weight. The resident received Vitamin D, ProStat BID and a Multivitamin (MV). Lactose free milk and ice cream was delivered to his/her unit to increase his/her calcium intake and the availability of homemade high protein milkshakes added to the resident's diet. Staff monitored and made other adjustments to the resident's care as needed.

A RD note dated 1/15/15 and timed 3:33 P.M. documented the resident enjoyed ice cream with caramel sauce at the end of the meal, chocolate lactose free ice cream had been ordered for her to provide more variety as well. The resident's weight declined 2.6 pounds in the past week, received a mechanical diet, and the resident's nutritional intakes in past week averaged 74% of meals, received a lactose free protein drink twice a day which he/she refused in the past 2 days. The resident received ProStat BID and Vitamin D and MV for further supplementation.

A RD note 1/23/15 and timed 4:11 P.M. documented the resident received a mechanical soft diet, weighed 110 pounds, received lactose free drink supplement which has deferred further weight loss. The resident received Vitamin D, a multivitamin and 30 cubic centimeters (cc's) of liquid protein supplement BID for supplementation. The resident's estimated nutrient needs were 1128 calories and 60 grams of protein daily.

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A RD note dated 2/12/15 and timed 1:10 P.M. included the resident consumed an average of 80% of meals and 9% of snacks. The resident refused the morning lactose free supplement 8 of 12 times and the afternoon supplement only twice and did not refuse the liquid protein supplement (ProStat). Staff offering the liquid protein supplement TID versus BID would increase the resident's protein intake as well as provide additional calories; 15 grams of protein and 70 calories. The past week chocolate syrup was added to the supplement and he/she accepted it in the morning much more than he/she did the first week of February, resulting in a much needed weight gain of 0.4 lbs. The RD recommended the continuation of this as well as the addition of more ProStat.

Review of the clinical record on 2/23/15 at 2:00 P.M. lacked evidence to support the facility followed up on the RD's recommendation made on 2/12/15 to increase the liquid protein supplement to three times a day (duration of 12 days) or add chocolate syrup to the resident's supplement.

Review of the December, January and February Medication Administration Record/Treatment Administration Record revealed the resident at times refused the lactose free supplement (Ensure) in the A.M. and P.M. Further review revealed the resident consumed all of the ProStat offered.

Review of the clinical record lacked evidence to support staff offered the resident another alternative or thoroughly assessed the causal factor as to why the resident refused the Ensure.

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Further review also lacked evidence to support staff documented the amount of Ensure the resident consumed when he/she did not refuse the Ensure.

Review of the clinical record lacked evidence to support staff offered the resident the lactose free supplement TID and also did not support staff documented the percentage of the supplement the resident consumed.

Review of the clinical record lacked evidence to support staff offered the resident lactose free ice cream.

On 2/18/15 at 9:56 A.M. the resident sat in the recliner in his/her room and observation revealed a standard bed pillow behind his/her back and no pressure relieving device in the seat of the recliner. Further observation revealed the resident's back had a curved position. Observation revealed the resident had a low air loss mattress in place on his/her bed and a pressure relieving device in his/her wheelchair. The resident stated he/she developed an area on his/her spine after admission to the facility. He/she stated there was not a lot to do in the unit, he/she laid in bed on his/her back a lot and staff did not reposition him/her or cue him/her to reposition. He/she stated staff did not treat the area and the area worsened. The resident stated the facility placed the low air loss mattress on his/her bed after she developed the pressure ulcer on his/her spine. The resident stated now staff placed pillows under his/her back when he/she was in bed.

On 2/18/15 at 10:15 A.M., 10:25 A.M., 10:43, A.M. and 11:02 A.M. the resident sat in the

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recliner in his/her room and observation revealed no pressure relieving device in the seat of the recliner and the pillow continued behind the resident's back.

On 2/18/15 at 12:14 P.M. the resident sat in his/her wheelchair and consumed the lunch meal which consisted of strawberries, roast beef with gravy, mashed potatoes and gravy, vegetable medley, (2) glasses of water. Observation revealed the resident ate independently and ate the last of the strawberries. Further observation revealed no pressure relieving device behind the resident's back.

On 2/18/15 at 12:20 P.M. the resident sat in his/her wheelchair in the dining room and observation revealed no pressure relieving device behind the resident's back.

On 2/18/15 at 12:35 P.M. the resident had finished eating and the resident consumed 75% of the roast, mashed potatoes and gravy and vegetables. Further observation revealed no pressure relieving device behind the resident's back.

On 2/18/15 at 12:37 P.M. staff offered a cookie, carrot cake and/or ice cream (not lactose free) and the resident chose carrot cake. Further observation revealed staff did not offer the resident lactose free ice cream. The resident consumed 75% of the cake.

On 2/18/15 at 12:50 P.M. the resident wheeled himself/herself from the dining room table to his/her room and transferred himself/herself to the recliner.

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F 314	Continued From page 35 On 2/18/15 at 2:15 P.M. Medical Director KK stated the area on the resident's spine was a pressure ulcer. Medical director KK stated the resident would benefit from a lumbar support device to keep the pressure off of the resident's spine when he/she sat in a chair. On 2/19/15 at 7:45 A.M. the resident sat in his/her wheelchair at a dining room table and a blanket placed behind his/her back. On 2/19/15 at 8:06 A.M. the resident sat in his/her wheelchair at a dining room table and ate the breakfast meal which consisted of 2 cups of water, a cup of coffee and a bowl of oatmeal with brown sugar. At 8:15 A.M. observation revealed the resident consumed all of the oatmeal and coffee. On 2/19/15 at 9:15 A.M. licensed nurse N and administrative nursing staff E performed the treatment to the pressure ulcer on the resident's mid-spine. Observation revealed the old dressing had a visible drainage stain approximately the size of a half dollar. Observation revealed the resident had a pressure ulcer on his/her mid-spine which administrative nursing staff E stated was a Stage 4. Further observation revealed a small bud of skin at the top of the wound and slough within the wound bed of the Stage 4 pressure ulcer. Administrative nursing staff E stated the Stage 4 pressure ulcer measured 3.2 cm by x 3.0 cm, the wound bed contained 10% slough and the wound had no tunneling. He/She stated the dark red area surrounding the Stage 4 pressure ulcer measured 2 cm. Administrative nursing staff E stated the Medical Director planned on debriding the	F 314		

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budding area and slough on the pressure ulcer on 2/23/15.

On 2/23/15 at 8:00 A.M. the resident sat in his/her wheelchair at a dining room table and no pressure relieving device or blanket behind the resident's back.

On 2/23/15 at 8:47 A.M. the resident sat in the recliner in his/her room, the red blanket the resident used at times behind his/her back when in the wheelchair was folded and laid on top of his/her bed, no pillow behind the resident's back and no pressure relieving device in the seat of the recliner. The resident stated he/she also used the blanket also for his/her bed, stated staff had folded the blanket this A.M. and placed it on his/her bed and he/she did not place the blanket behind his/her back when he/she sat in the wheelchair during breakfast. He/she confirmed no pillow was placed behind his/her back as he/she sat in the recliner at that time. The resident stated facility staff only offered him/her Ensure during the early afternoon each day. The resident stated he/she only refused the supplement if staff offered it too close to dinner time or offered him/her strawberry flavored versus chocolate flavored. He/she stated staff did not consistently offer him/her lactose free ice cream and did not offer him/her milkshakes.

On 2/23/15 at 10:20 A.M. direct care staff W made milkshakes in the kitchenette. Direct care staff stated he/she offered the milkshakes to residents during snack time. A staff provided a list of residents that received nutritional supplements between meals. Review of the roster revealed this resident received lactose free milkshakes TID. According to the staff the

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resident received the lactose free milkshake at 10:00 A.M. , 2:30 P.M. and prior to going to bed each night.

On 2/23/15 at 10:35 A.M. direct care staff W had 4 strawberry and 4 vanilla milkshakes and offered the milkshakes to 4 residents attending a group activity. Observation revealed the resident was not one of the residents that attended the activity. Direct care staff offered 2 residents in the general proximity the milkshakes and then offered the other 2 milkshakes to 2 other residents. Observation revealed the resident was not offered a milkshake. During interview direct care staff W stated he/she offered the milkshakes to the residents that attended the activity and then offered the remaining milkshakes to residents he/she thought would enjoy the shakes and not to residents included on list to receive milkshakes. Direct care staff W stated he/she made (2) pitchers of milkshakes and added a cup of protein powder to each pitcher of milkshakes.

On 2/23/15 at 11:20 A.M.. licensed nurse LL stated the resident at times refused the A.M. Ensure. He/she stated the resident stated he/she did not like the vanilla flavored Ensure so staff now offered the resident either strawberry or chocolate flavored Ensure. Licensed nurse LL stated the resident received ProStat BID.

On 2/23/15 at 11:45 A.M. direct care staff TT stated the resident was not on a turning/repositioning program. He/she stated the resident asked for staff assistance when he/she needed repositioning. Direct care staff TT stated staff placed a pillow behind the resident's back when the resident sat in the wheelchair and/or recliner. Direct care staff TT stated the resident

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was not offered a milkshake during evening snacks.

On 2/23/15 at 1:33 P.M. licensed nurse N stated staff offered the resident (1) can of Ensure BID, and milkshakes with added protein BID. He/she stated direct care staff offered the resident the milkshakes between 9:45 A.M. to 10:15 A.M. and around 2:30 P.M. Licensed nurse N stated the resident consumed all of the liquid protein, typically refused the Ensure but did consume the milkshakes. He/she stated upon admission the resident had a fractured pelvis, was not moving much and was not compliant with turning and repositioning and the resident did not understand how bad his/her back was getting. Licensed nurse N stated the resident received pain medication and did not have full sensation to know that he/she was hurting. Licensed nurse N stated the resident was compliant in this unit, and turned from side to side. He/she stated the resident leaned over when he/she sat in the wheelchair and recliner and was cautious not to put pressure on his/her spine; therefore no pillow/pressure relieving device was placed behind the resident's back when the resident sat in the wheelchair or the recliner. Licensed nurse N stated at times the resident asked staff to place a pillow between his/her legs.

On 2/23/15 at 2:23 P.M. dietician consultant DD stated the resident received Ensure BID, Lactose free milkshakes TID, and he/she recommended the resident receive ProStat TID versus BID. He/she stated if the resident received all of the above as planned the resident would have better wound healing. Dietician consultant DD stated he/she was unaware the ProStat was not increased to TID.

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F 314	Continued From page 39 On 2/23/15 at 2:45 P.M. dietician consultant DD stated nursing staff contacted the resident's physician and he/she gave the order to increase the ProStat to TID. On 2/23/15 at 5:18 P.M. nursing administrative staff D stated upon admission the resident was considered at risk for the development of pressure ulcer and required staff assistance with ADL's. He/she stated staff placed an air loss mattress on the resident's bed upon admission and was unsure of the date the facility placed the resident on a low air loss mattress. Nursing administrative staff D stated after staff observed the red area on the resident's back, they discussed repositioning/turning with the resident. He/she stated when the resident resided on the rehab unit the resident was not on staff's radar the resident did not turn. Nursing administrative staff D stated with staff persistence, encouragement and explaining the importance of turning/repositioning when in the wheelchair and recliner the resident was compliant with turning/repositioning. He/she stated the resident did not use a pressure relieving device/lumbar support when he/she sat in the wheelchair or recliner because Medical Director KK did not recommend it and the resident had not requested one. Nursing administrative staff D did not know why the resident utilized the pillow/blanket behind his/her back when in the wheelchair/recliner. Administrative nursing staff D stated he/she was not sure if the facility had thoroughly assessed why the resident refused the supplements. Nursing administrative staff D stated the facility documented the resident accepted/refused snacks but did not identify what snack staff offered the resident (milkshake, ice cream, etc.)	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	02/25/2015

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F 314	Continued From page 40 He/she stated the facility should record the percentage of Ensure the resident consumed. Nursing administrative staff D confirmed the facility did not record the percentage of Ensure the resident consumed. The facility's Skin Protection Protocol for Elders at Risk for Pressure Ulcers approved 12/15/14 included characteristics of elders at risk for pressure ulcers included residents who scored 16 or lower on the Braden scale...A pressure relieving device would be placed in the resident's chair if the resident scored 16 or below on the Braden Scale. The pressure relieving device would be placed in any chair the resident sat in...If the resident had a condition or presented with bony prominences measures would be taken to prevent breakdown. Examples included residents with kyphosis-Elastogel would be applied. The facility failed to develop and implement appropriate interventions to prevent the development of an avoidable stage 4 pressure ulcer, and failed to ensure the resident received the milkshakes as planned, failed to ensure the resident had an adequate pressure relieving device/lumbar support to minimize the pressure off of his/her spine when he/she sat in the wheelchair and also failed to develop a temporary care plan that addressed pressure ulcers interventions for this resident assessed upon admission at risk for the development of pressure ulcers.	F 314		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 41 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility reported a census of 95 residents	F 441		

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F 441	Continued From page 42	F 441		

with 5 neighborhoods. Based on observation, interview and record review the facility failed to track and trend infection control data and failed to provide a safe, sanitary, comfortable environment and prevent the development and transfer of disease and infection when staff failed to properly disinfect a resident ' s room.

Findings included:

- On 2/23/15 a t2:40 PM: Infection control logs for 12/14 through 2/15 (last entry 2/11/15) revealed the logs contained the residents name, household, date, type of culture, antibiotic, and if the infection was facility or community acquired. The log failed to have tracking/trending of the infection which looked for clusters or an infection control rate. The log also failed to list the resident who had tested positive for influenza.

On 2/23/15 at 3:25 P.M. administrative nursing staff D revealed that the facility had started doing percentages this month. He/she confirmed that the resident who test positive for influenza was not on the 2/2015 log.

The facility failed to have an effective infection control program.

- On 2/23/15 at 9:55 A.M., direct care staff WW sprayed the inside of the sink with 20% Total Restroom Cleaner, wiped the sink, faucet handles, the vanity, top of toilet, grab rail and behind and beside the toilet with the same cloth. He/she then sprayed the 20% Total Restroom Cleaner inside the toilet bowl, wiped it down and then flushed the toilet. He/she then used a cloth and the 20% Total Restroom Cleaner to wipe the

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F 441	Continued From page 43	F 441		

inside and outside of the toilet seat. Staff WW then wiped down the furniture with luster mist furniture polish but failed to disinfect the door handles.

An interview on 2/23/15 at 1:57 P.M., housekeeping supervisor Y revealed the areas should have been cleansed with a sanitizing product.

The Cleaning an Elder ' s Bathroom Policy dated 8/25/11 revealed the staff needed to use a cloth moistened with sanitizer to wipe all surfaces such as countertops, paper towel and soap dispensers, towel bars, door handles and cabinet door. Cleanse lavatory and around faucets with a chlorinated cleanser and green scouring pad. Spray sink, underside of sink and faucets with sanitizer and wipe dry. Wipe grab bars with cloth moistened with sanitizer.

The facility failed to properly clean a room when staff failed to disinfect frequently touched areas and failed to use a chemical in the toilets that had a germicidal.